State:

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Wisconsin enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

✓ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
✓ ii. capitation;
____iii. a case management fee;
____iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.
If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

Citation	Condition or Requirement
	____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
	____ii. Incentives will be based upon specific activities and targets.
	____iii. Incentives will be based upon a fixed period of time.
	____iv. Incentives will not be renewed automatically.
	____v. Incentives will be made available to both public and private PCCMs.
	____vi. Incentives will not be conditioned on intergovernmental transfer agreements.
	____vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

The State has a process in place to involve the public in both the design and implementation of the SSI-Medicaid Managed Care Program. The Department has established an Advisory Committee to address programmatic design issues and policies that require decisions prior to implementation. The committee consists of disabled persons and family members, advocates for the SSI-disabled population, providers, MCO representatives and Department staff. The committee began meeting in July 2004 and will continue to meet on a regular basis during and after implementation. The meetings are monthly and last 3 to 4 hours. Smaller workgroups have been formed from the larger committee to work on the details of implementation. The Advisory Committee has direct input into the Department's State Plan Amendment, contract with the MCOs, and the certification requirements. During the implementation phase, the Department will hold statewide advisory committee meetings. Through this committee, MCOs, providers, and community representatives will assist the Department in developing tools for monitoring MCO performance during implementation. The Committee will remain in tact following implementation to make recommendations on changes to policies, technical specifications, and specific program design characteristics.

Citation	Condition or Requirement
1932(a)(1)(A)	5. The state plan program ~~will~~ ___/will not ✓ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ✓ / voluntary_____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _Milwaukee_ ii. county/counties (voluntary)_____ iii. area/areas (mandatory)_____ iv. area/areas (voluntary)_____
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ✓ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2)	2. ____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1902(a)(23)(A) 1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ✓ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. ✓ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. ✓ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c)	6. ✓ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

Citation	Condition or Requirement
42 CFR 438.50(c)(6)	
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. ✓ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met. The State will certify all willing and qualified providers to participate in the program.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. The SSI-Medicaid Managed Care Program is limited to the following target groups of recipients nineteen years and older who are determined disabled through: Supplemental Security Income (SSI) and related eligibility criteria.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ✓ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)* Dual eligibles may enroll on a voluntary basis at any time. Recipients who become Medicare eligible during enrollment remain eligible for managed care and are not disenrolled into fee-for-service unless they request it.
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ✓ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian

Citation	Condition or Requirement
	Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ___ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI. Recipients who are 18 years of age and under 19 may not enroll.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ___ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ___ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ___ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. <u>Identification of Mandatory Exempt Groups</u>
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* Children through age 18 may not enroll in this managed care program.
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ____i. program participation, ____ii. special health care needs, or ____iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated

Citation		Condition or Requirement
		care system. ____i. yes ____ii. no
1932(a)(2) 42 CFR 438.50 (d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; People under 19 years of age who are eligible for SSI under title XVI are not eligible to enroll in this managed care program. They are identified by date of birth and medical status code, both from the Medicaid eligibility database. Children under the age of 18 are not eligible to enroll – identified by date of birth in the eligibility database. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; People eligible for Medicaid under section 1902(e)(3) of the Act are not eligible to enroll in this program. They are identified by medical status code. iii. Children under 19 years of age who are in foster care or other out-of-home placement; Children under 19 years of age who are in foster care or other out-of-home placement are not eligible to enroll in this program. They are identified by medical status code. iv. Children under 19 years of age who are receiving foster care or adoption assistance. Children under 19 years of age who are receiving foster care or adoption assistance are not eligible to enroll in this program. They are identified by medical status code.
1932(a)(2) 42 CFR 438.50(d)	5.	Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* N/A

Citation	Condition or Requirement

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

Recipients who are also eligible for Medicare are assigned a medical status code in the eligibility system based on a direct link with SSA.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

The State accepts self-identification .

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

None.

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

Recipients eligible under the Medical Assistance Payment Plan

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

Citation	Condition or Requirement

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

If a recipient has a prior relationship with a provider who has traditionally served Medicaid recipients and the recipient wishes to maintain this relationship, the enrollment broker will assist in choosing an MCO that maintains this relationship through one-on-one enrollment counseling and informing services as per 42 CFR 438.50(f).

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

The enrollment broker provides enrollment counseling which includes providing information on which MCOs are available to maintain a prior patient-provider relationship with a provider that has traditionally served Medicaid recipients.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

If the recipient fails to choose an MCO within two months after receiving enrollment materials, the State will assign the recipient to an MCO. These recipients are automatically assigned, where it is not possible to determine prior patient/provider relationship, on a rotational basis to MCOs that are below their maximum enrollment to ensure equitable distribution to individual MCOs.

1932(a)(4)

3. As part of the state's discussion on the default enrollment process, include

Citation	Condition or Requirement
42 CFR 438.50	the following information:

i. The state will ✓ /will not____ use a lock-in for managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be two months following receipt of enrollment materials.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

After the assignment is made, the MMIS system generates correspondence to the enrollee informing them of the assignment. The notice also informs the recipient that they have 120 days to change HMOs, or if they choose, they can return to fee-for-service after a 60 day trial of managed care.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The enrollment broker supplies an enrollment packet to the recipient that includes information about the right to change MCOs in the first 120 days or to return to fee-for-service after a 60 day trial of managed care. In addition, the notice generated by the system informing the individual of their MCO assignment, informs him of his right to change MCOs during the first 120 days of enrollment.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

If the recipient fails to choose an MCO within two months after receiving enrollment materials, the State will assign the recipient to an MCO. These recipients are automatically assigned, where it is not possible to determine prior patient/provider relationship, on a rotational basis to MCOs that are below their maximum enrollment number to ensure equitable distribution to individual MCOs.

Citation	Condition or Requirement

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State will be generating reports on a regular basis to monitor the number of enrollees who choose an MCO compared to the number automatically assigned. The Advisory Committee will be provided with this data.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. ✓ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. ✓ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ___ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   ✓ This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity.

   ✓ This provision is not applicable to this 1932 State Plan Amendment.

5. ✓ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

Citation	Condition or Requirement

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will ✓ /will not___ use lock-in for managed care.

2. The lock-in will apply for _8_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

✓ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

Poor quality of care, lack of access to special services, maintaining continuity of care, or other reasons satisfactory to the State.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

✓ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Prenatal Care Coordination (obtained on a FFS basis).

Tuberculosis-related Services (obtained on a FFS basis).

Targeted Case Management(obtained on a FFS basis).

Chiropractic services – (optional for MCOs – can be obtained on a FFS basis).

Community support program services for the chronically mentally ill (obtained on a FFS basis).

Citation	Condition or Requirement

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not ✓ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ✓ The selective contracting provision in not applicable to this state plan.